

INDIANA PRESCRIPTION DRUG PLAN FOR SENIORS

State Form 49905 (R6 / 6-04) / PDP 0001



What is HoosierRx?

HoosierRx is Indiana's prescription drug plan for seniors. It is funded by the State's Tobacco Settlement funds. With the HoosierRx drug card, you could:

- ✓ Receive most prescription drugs, brand name and generic, as well as insulin, at a less than retail price.
- ✓ Receive a 75% discount off the cost of prescription drugs, up to your maximum benefit level.

Are you eligible for HoosierRx?

- ✓ You must be age 65 or older, and be an Indiana permanent resident.
- ✓ You <u>can</u> have a Medicare-Approved Drug Discount Card or other drug discount card and HoosierRx.
- ✓ You <u>cannot</u> already have prescription drug insurance or Medicaid.
- ✓ Your monthly income received must be:
 - Single person \$1,068 or less a month
 - Married couple \$1,426 or less a month

How much will you save?

Benefit amounts are determined by the time you apply. All benefits are available through December 31, 2005.

Enrolled during	June '04 -	Oct. '04 -	Jan. '05 -	Aprl '05 -	July '05 -	Oct. '05 -
	Sept. '04	Dec. '04	Mar. '05	June '05	Sept. '05	Dec. '05
Your benefit is	\$1,200	\$1,000	\$800	\$600	\$400	\$200

HoosierRx will pay 75% of the cost, up to your maximum limit, as stated in the chart above. **You will pay 25%**. After you have used your maximum benefit limit, you will still receive prescriptions at a less-than-retail price, if you continue to use your HoosierRx Drug Card.

How do you apply for HoosierRx?

Complete this short application - front and back - and sign your name on the back. If you are eligible, you will receive your HoosierRx Drug Card to take to your local pharmacy for your discount. Remember to attach your income papers to your application before sending it in. Examples of income papers are bank statements or letters from Social Security. See top back section for more information.

1-866-267-4679 (*toll free*) <u>www.IN.gov/HoosierRx</u>

Application For The HoosierRx Drug Card This application continues on the back side.									
Who is applying for the HoosierRx program?									
Information About You:									
Name of applicant (first name, middle initial, last n		Telephone number (include area code)							
			()					
Date of birth (month, day, year) Social Security		mber of applicant		Sex:					
				☐ Male	☐ Female				
Home mailing address (number and street, city, st	tate, ZIP code)								
Race (optional)	Marital status:								
		☐ Single	☐ Marri	ed 🗌 W	/idowed				
Other mailing address (if different from above) (other	her authorized name	e, number and street, c	city, state, ZIP co	ode) - P.O.A. se	end proof				
Other telephone number (include area code)									
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INFORMATION ABOUT YOUR SPOUSE //s more	riad and living to a	other way must sar	nnloto this so	ection and so	and conice of				
INFORMATION ABOUT YOUR SPOUSE (If married and living together, you must complete this section and send copies of the monthly income for you and your spouse, even if only one of you is applying for benefits.)									
Name of spouse (first name, middle initial, last na		Date of birth of spouse (month, day, year)							
Social Security number of spouse	Race of spouse (optional)								
			,						
Information About Your Dependent Child	/ Children:								
If you have any dependent children, you must sub		tion about the child(ren	ı) on a separate	piece of paper	and attach it to				
your application. For each dependent child, please	e provide the child's	name, date of birth, So	ocial Security nu	ımber and doc	uments to prove				

income for that child. Remember, a qualifying dependent(s) is either your biological or adoptive child (under 18 or a student 18-21 years old) or a child for whom you have legal guardianship / custody through a court. If you do not have any dependent children, please move on

So we can determine if you are eligible, you must send us papers to show your current monthly income you receive this year or your application will be denied. Follow these 3 steps: 1. Write the amount you receive each month in each box. If you do not receive that type of income, leave the box blank. 2. Attach a paper, such as your bank statement or letters from Social Security, to prove your monthly income. 3. If you are married, attach income papers for your spouse too, even if only one of you is applying. Types of Income You May Receive Applicant (You) **Spouse** 1. Social Security (the amount of your monthly check), \$ Supplemental Social Security Income or Railroad Retirement income. \$ \$ 2. Pensions, retirement income, annuities, veteran's benefits. 3. Interest and dividends (If joint accounts, please place amount under the \$ \$ "applicant" column only.) \$ \$ 4. Other income (wages, rental income, non-taxable income) \$ \$ ΤΟΤΔΙ Your Insurance Information (Answer all questions) Do you receive Medi<u>care</u>? (You <u>may</u> have a Medicare-Approved Drug Discount Card and still be eligible for HoosierRx.) Are you on Indiana's Medicaid program or on Medicaid with a spend-down? ☐ Yes ☐ No Do you have an insurance plan that helps pay for prescriptions? ☐ Yes ☐ No What is the name of this insurance plan? Explain how your insurance plan helps you pay for your prescription drugs: Do you actually have a prescription drug discount card? ☐ No Your Spouse's Insurance Information (Complete only if spouse is applying as well.) Does your spouse receive Medicare? (You may have a Medicare-Approved Drug Discount Card and still be eligible for HoosierRx.) Is your spouse on Indiana's Medi<u>caid</u> program or on Medi<u>caid</u> with a spend-down? ☐ Yes ☐ No Does your spouse have an insurance plan that helps pay for prescriptions? ☐ Yes ☐ No What is the name of this insurance plan? Explain how your spouse's insurance plan helps you pay for your prescription drugs: Does your spouse actually have a prescription drug discount card? ☐ Yes ☐ No Please read the information below, sign and mail the application with your income papers: I understand that I/we must complete this application in full or this application will not be accepted. I understand that information I/we provide is confidential and will not be disclosed without my consent for any purpose that is not related to HoosierRx (PL 42 USC 405(c)(2)(C)(i)/IC 4-1-6-2/IC 4-1-8-2). I authorize Medicaid to release information about Medicaid eligibility to HoosierRx. I will inform HoosierRx if I acquire insurance to help pay for prescription drugs. I reside permanently in Indiana. I certify, under the penalty of perjury, that all the information I have provided is complete and correct to the best of my knowledge. Signature of applicant's spouse (if applying) Signature of applicant Date (month, day, year) X X Where did you hear about HoosierRx? Did you remember to: ☐ Sign the application; and ☐ Area Agency on Aging Pharmacy/Drug Store AARP Presentation ☐ Send us your papers to show your Doctor's Office Radio income with your application? Senior Center ☐ Energy Assistance Program ☐ Meal Site ☐ SHIIP Send your application and income ☐ Medicare ☐ Social Security Office papers to: Minority Health Coalition ☐ Television/TV Township Trustee **HoosierRx** Newspaper ☐ Other _ ☐ Office of Family and Children P.O. Box 6224 Indianapolis, IN 46206-6224

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Questions? - Call us toll-free at 1-866-267-4679 or visit our web-site at www.IN.gov/HoosierRx